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Eliot Fishman
Director
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Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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RE: Comments on Maryland HealthChoice Program 1115 Waiver Renewal Application

Dear Mr. Fishman,

Thank you for the opportunity to comment on the *Maryland HealthChoice Program 1115 Waiver Renewal Application*. The Baltimore City Health Department strongly supports the state's waiver renewal and expansion of key services that, if properly financed, would significantly enhance our ability to provide services to our city's most vulnerable Medicaid beneficiaries.

We were pleased to submit comments directly to the Maryland Department of Health and Mental Hygiene prior to their submission of the waiver renewal application to the Center for Medicare and Medicaid Services. This letter further underscores key components of that feedback that we believe are essential in ensuring robust quality of care for our patients. These include:

1. **Community Health Pilot: Home Visiting**

Background. Baltimore City has had a longstanding commitment to reducing infant mortality and improving infant and maternal health among its residents. Providing home visits to support pregnant women and new mothers has been a key element of the *B'More for Healthy Babies (BHB)* initiative, which began in 2009. BHB also partners closely with Baltimore's Promise, a city-wide collaborative of local leaders across sectors that organize efforts and resources to help youth travel a safe, healthy, and successful educational path from cradle to career, and the Family League of Baltimore. Before BHB began in 2009, the infant mortality rate in Baltimore was 13.5 per 1,000 births, the fourth highest rate in the United States and higher than many less developed countries. In 2009 alone, 127 babies died before their first birthday and African American babies were five times more likely to die than white babies.

BHB's vision is to for all babies to be born at a healthy weight, full-term and ready to thrive in healthy families. In addition to work organizing communities and advocating for polices supporting the health and wellbeing of Baltimore's families, the program provides a wide range of services to support

preconception health of young women and men, pregnant women, mothers, fathers, babies and their families. Services include access to early intervention for infants and toddlers, preconception health, family planning, prenatal care and education, home visiting services, education and health literacy including a safe sleep campaign and moms/dads support clubs, cribs for families, support for pregnant women and mothers and care givers with substance use issues, as well as care coordination and referrals to other providers and organizations that can help address medical and social support needs.

Although our BHB initiative has cut the infant mortality rate by 28% since 2009, Baltimore City still accounts for 55% of the state's excess infant mortality. And the infant mortality rate is 56% higher among Medicaid enrollees—12.1 deaths per 1,000 live births compared with 6.4 deaths per 1,000 live births for women not supported by Medicaid between 2011 to 2014. Given that African-American infants are still twice as likely to die as Caucasian infants; with a population that is 63% African-American, the majority of Baltimore infants are at higher risk of death.

As more and more women have benefitted from BHB, the target population for the work has become harder and harder to reach. Based on findings from the Baltimore City Fetal and Infant Mortality Review and Child Fatality Review Teams, the remaining population is more transient, more likely to be involved in substance use, and often struggles with mental health issues and other chronic conditions. These stark facts make the availability of additional federal Medicaid support a critical element of the long-term sustainability of the BHB initiative.

Given this context, we were very pleased to see that the Department of Health and Mental Hygiene is taking advantage of the federal Medicaid opportunity to establish a Medicaid Evidence-Based Home Visiting Pilot program ("HV Pilots"). These Pilots would invest much needed funding into continuing to improve evidence-based and innovative initiatives that are making a real difference in the lives of high-risk mothers and their infants.

Home Visiting in Baltimore. As noted above, home visiting services have been a critical element of the *B'More for Healthy Babies* initiative. The City has supported home visits through the Healthy Families America (HFA) model for 700 families and is in the process of establishing its Nurse Family Partnership (NFP) program to support up to 100 families over the next 12 months. These programs are supported by City General Funds, the Governor's Office of Children, and foundation contributions. While some parts of the BHB initiative are funded by Medicaid, the vast majority of services provided are not Medicaid-funded, despite the fact that upwards of 90% of the women served in the program are enrolled in Medicaid.

While the inclusion of the HV Pilot in the waiver proposal is a strong first step toward promoting sustainability of home visiting services through BHB, we have some concerns about the proposal's ability to truly improve maternal and infant health as currently structured:

- Expand eligibility for home visiting under the Healthy Families America Model to age 5. The national definition of the evidence-based HFA model provides for home visits up to age five, as appropriate. However, the Maryland waiver proposal limits reimbursable home visiting services up to age two. The current HFA program in Baltimore provides home visits up to a minimum of age three, but under certain circumstances extends until the child's 5th birthday.

As such, the waiver as proposed amounts to a reduction in home visiting benefits for these families.

The HFA is a model designed for families that tend to be, in comparison to families served by other models, at higher risk in terms of their life circumstances. Continuing home visits beyond a child's second birthday helps accommodate a greater level of need and/or risk that families may have and also ensures greater continuity of services during the period between ages 3 – 5 when there are typically few resources available to help children. It is estimated that 60-80% of families (parents and children) participating in HFA have experienced an adverse childhood experience and therefore its approach is consistent with the trauma-informed practice literature and research on adverse health experiences.

- Opportunity for new Evidence-based models to be included. Given that there are a number of other evidence-based home visiting models underway nationally, and in Maryland, it would be helpful if the waiver included a third option in addition to Healthy Families America and Nurse Family Partnership that might be titled "Other evidence-based home visiting practices as determined appropriate." For example, in Baltimore, we are currently working with Sinai Hospital of Baltimore to pilot a home visiting model based on Durham Connects. If that pilot proves to be successful, it would be important to be able to include it under the waiver.

- Provide details on care coordination, data sources and reporting requirements, universal and variant metrics, performance requirements and related funding. As noted above, home visiting services are not currently part of the responsibility of the state's Medicaid managed care organizations (MCOs) even though the vast majority of the women served are enrolled in Medicaid. We request clarification around the requirements for how the HV Pilots must coordinate with the MCOs and whether they will be required to interact with the Pilots. If MCOs are not required to engage and/or do not have an incentive to work closely with HV Pilots, we are concerned that the system will continue to be siloed and that the families will suffer from the lack of coordination.

  The application elements note that payments will be contingent upon specific deliverables or the achievement of HV Pilot outcomes as measured by universal and variant metrics. The proposal also notes that HV Pilots must include performance measures for each type of participating entity and the HV Pilot itself. It would be helpful if DHMH could outline the types of deliverables, process measures and outcomes that they envision for the HV Pilots, including how Pilots would be expected to assess performance of the Lead and participating entities. In addition, the home visiting programs that are funded under MIECHV already report a significant amount of data as part of those grants, so it seems critical that the performance measures align with those already being collected. Given that the HV Pilot is only 2.5 years, it will be difficult to set up new data systems and realize performance improvements in a short timeframe.

- Require State contribution to support the Community Health Pilots. The waiver proposal limits the amount of available federal Medicaid funding to $4.8 million over the course of the 2 ½ year Pilot, but does not include any allocation of state funds to support the expansion of Medicaid benefits. All HV Pilot federal matching funds must be provided by the participating

counties. While Baltimore City does have currently allocated general funds for home visiting available to provide to the state for matching purposes, the absence of a state investment in these Pilots severely limits their ability to be more broadly effective in Baltimore and across the state of Maryland.

2. **Expansion of Substance Use Disorder Coverage and Services.**

Background. We concur with DHMH that heroin and opioid abuse is truly an epidemic and a public health emergency – one that is claiming the lives, the livelihoods, and the souls of our citizens. In Baltimore, we are experiencing this epidemic head on: There are approximately 19,000 active heroin users in Baltimore City and last year, 303 people died from drug and/or alcohol overdoses.

The lack of available treatment, particularly residential treatment, is a key barrier to effectively combatting the opioid epidemic. Nationwide, as well as in Maryland and Baltimore City, only 1 in 10 individuals with addiction receives the treatment that they need. Substance abuse is both a significant comorbidity and a driver of healthcare costs, and this treatment disparity would not be tolerated for health conditions like cancer or diabetes.

Opioid and Overdose Prevention in Baltimore. Baltimore City has developed a comprehensive opioid prevention and treatment framework that has received national recognition from the White House and on Capitol Hill. A core pillar of this framework focuses on expanding the number of residential treatment slots, and we strongly support DHMH's proposal to claim expenditure authority for substance use disorder treatment in non-public institutions for mental disease (IMDs), otherwise-covered services for Medicaid beneficiaries who are enrolled in a Medicaid MCO and reside in a non-public IMD, and reimbursement for two 30-day stays annually. The state's waiver proposal will significantly address the current gap in coverage that exists as a result of the federal exclusion of matching federal funds for treatment in certain IMDs.

Mental Illness Reimbursement in IMDs. In addition to expenditure authority for substance use disorder treatment, we also encourage DHMH to pursue a process to seek Medicaid reimbursement for individuals with serious mental illness in IMDs. Given the interconnected nature of behavioral health and substance use disorders, we believe this will significantly reduce costs and ensure maximally effective treatment.

Focus on Substance-Exposed Pregnancies. Dozens of infants are born substance-exposed each month in Baltimore City. Our Fetal-Infant Mortality Review and Child Fatality Review projects, which bring together city stakeholders to review cases of infant and child death occurring in the City, have shown that these infants are at very high risk: in a review of 25 recent cases, infants and young children who were born substance-exposed died or were seriously injured from unsafe sleep, child maltreatment, and prematurity/stillbirth.

As described below in comments on home visiting services, BCHD has prioritized these families for services. However, enrollment capacity is limited and must be expanded to enable us to tackle this crisis. Meeting the needs of these families—which face multiple risks, including violence and abuse, unstable housing, and poor health—requires extensive outreach, a highly trained home visiting workforce, and access to intensive services.

We request that the Department consider adding an initiative to this waiver proposal focused on prevention and treatment of babies born with substance-exposure and Neonatal Abstinence Syndrome (NAS). Including a targeted initiative focused on this population has significant potential to save the lives of vulnerable infants and to prevent accidental injury and deaths caused by substance abuse.

3. Additional Considerations

24/7 Sobering Services. In addition to the proposed expansion of SUD treatment services put forward in this application, we also strongly encourage DHMH to consider incorporation of 24/7 sobering and mobile crisis response services into the renewal application. In Baltimore City we are currently in the process of launching a sobering center that will make these services available -- going beyond ASAM levels of care to serve as a critical entry point for connecting individuals in need of behavioral health treatment with fast, responsive care. This approach will significantly accelerate local and state-wide capacity to reduce opioid overdose deaths as well as provide expanded treatment on demand.

Reimbursement for Comprehensive Wraparound Case Management. While coverage is an essential component of health access, additional efforts are needed to ensure that patients actually receive the care that they need. One of the widely accepted strategies for ensuring that Medicaid beneficiaries achieve improved health outcomes is to provide comprehensive care coordination/case management services.

For example, the temporary Medicaid enrollment provision for returning citizens, cited above, is an essential first step in covering this beneficiary population. However, to ensure that returning citizens remain covered, as well as actually access a primary care provider that can provide ongoing care, the majority of these patients will require case managers who can provide targeted, one-on-one follow-up.

In keeping with national and state trends, case management models have begun to move beyond intensive, clinically-based models and towards usage of community health workers and peer specialists. There are several advantages to supporting and deploying these paraprofessional workforces. First, they are typically hired from the same communities as the patient themselves, bringing a nuanced knowledge of available resources as well as an ability to build strong social and cultural connections. Returning citizens, for example, may be more likely to remain insured and access care if they are in regular communication with a peer case manager who is also a returned citizen. Second, these workforces are cost-effective, typically providing case management services at a fraction of the cost of full-time clinical professionals. Third, they represent a workforce development solution in addition to a healthcare solution, through creation of local jobs.

BCHD has significant experience with deploying case managers and peer specialists:

- Peer Recovery Specialists – Peer recovery specialists are individuals in recovery who provide targeted case management support to individuals undergoing behavioral health treatment. They are able to draw upon their own experiences to connect with patients that may be difficult to reach or resistant to access healthcare as a result of stigma and/or prior experiences with the system.
- Safe Streets Violence Interrupters – Safe Streets takes a public health approach to violence and deploys "violence interrupters," ex-offenders and gang members who are intimately familiar with the communities where violence is taking place. The program has proven successful in

significantly reducing incidences of shootings and homicides: in 2014 alone, the program had 15,000 client interactions and 800 mediated conflicts, more than 80% of which were deemed likely or very likely to have resulted in gun violence.

- Community Health Workers and Navigators– BCHD also deploys community health workers and navigators who provide comprehensive wraparound services to several vulnerable Medicaid patients including those who are HIV positive; children attending city schools; and more. These staff provide essential connection services and also drive effective healthcare utilization, decreasing emergency room visits/readmissions and reducing cost.

We ask that DHMH consider provisions to expand reimbursement capacity for health-related services provided by the above workforces.

Thank you for the opportunity to provide comments and your consideration of these requests. We at BCHD look forward to working with DHMH upon the approval of this waiver application to make Maryland a national model for health equity and ensuring better health for all of our citizens.

Sincerely,

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Baltimore City Health Commissioner